

FILE COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

December 17, 2014

Bryan K. Lindsay, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815-7764

Provider #: 135122

Dear Mr. Lindsay:

On **December 5, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Life Care Center of Coeur d'Alene by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

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return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 30, 2014**. Failure to submit an acceptable PoC by **December 30, 2014**, may result in the imposition of civil monetary penalties by **January 19, 2015**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **January 9, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 9, 2015**. A change in the seriousness of the deficiencies on **January 9, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 9, 2015** includes the following:

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Denial of payment for new admissions effective **March 5, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 5, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 5, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

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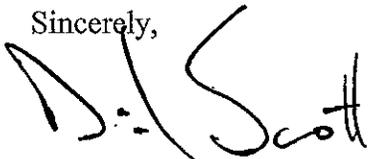
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **December 30, 2014**. If your request for informal dispute resolution is received after **December 30, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

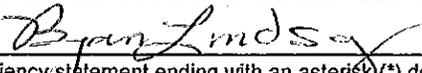
PRINTED: 12/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2014
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification and complaint investigation survey of your facility.</p> <p>The surveyors who conducted the survey were: Linda Kelly, RN, Team Coordinator; Brad Perry, LSW; Lauren Hoard, RN, BSN; and Judy Atkinson, RN.</p> <p>The survey team entered the facility on 12/1/14 and exited on 12/5/14.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BFS = Bureau of Facility Standards CAA = Care Area Assessment CMS = Centers for Medicare & Medicaid Services CNA = Certified Nurse Aide DON = Director of Nursing IDT = Interdisciplinary Team LN = Licensed Nurse LSW = Licensed Social Worker MD = Medical Doctor MDS = Minimum Data Set assessment MG = Milligram MAR = Medication Administration Record O2 = Oxygen PRN = As Needed R/T = Related to SNF = Skilled Nursing facility TAR = Treatment Administration Record W/C = Wheelchair</p>	F 000	<p><i>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</i></p> <p style="text-align: center;">RECEIVED JAN - 2 2015 FACILITY STANDARDS</p>	1-7-15
F 204 SS=D	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and</p>	F 204		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 12-30-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 204	<p>Continued From page 1 orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>This REQUIREMENT is not met as evidenced by: Base on closed record review and staff interview, it was determined the facility failed to ensure that residents were provided with discharge medication lists they could understand. This was true for 1 of 1 (#16) sampled residents reviewed for discharge instructions. Findings included:</p> <p>On 10/10/14 at 2:25 PM Resident #16 was discharged home as documented in the discharge summary and E-Signed by LN #14, who stated that the resident was discharged home with, "Copies of meds [medications] and discharge information." The discharge medication list, dated and signed by the Medical Director on 10/10/14, provided instructions on how often to take the medication in medical terms like, PO (by mouth), Q6 (every 6 hours), Subq (subcutaneous) 4xday (4 times a day), BID (twice a day), and PRN (as needed), rather than in simple understandable terms.</p> <p>The facilities Admission, Transfer and Discharge procedure stated the resident would be provided with "a list of medications with simplified</p>	F 204	<p>F204 SPECIFIC RESIDENT Resident discharged</p> <p>OTHER RESIDENTS</p> <p>Residents who discharge from the facility will be provided with medication lists and teaching in laymen terms. Medical terms or abbreviations generated by the computer system will be reviewed and re-written in order to assure the resident is able to understand upon discharge.</p> <p>SYSTEMIC CHANGES</p> <p>Root cause indicates this is a staff education on admission, transfer and discharge procedure to ensure the list of medications are provided with simplified instructions.</p> <p>Licensed Nurses and social services have been educated on writing the discharge instructions and medication lists in laymen terms and providing this to the resident upon discharge.</p> <p>MONITOR</p> <p>Discharge instructions will be audited by social services department to ensure discharge teaching instructions are clear and easy to understand. The results of the audits will be reviewed at our monthly QA meeting for review and action taken as necessary.</p> <p>COMPLIANCE DATE: 1/7/15</p>		

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F 204	Continued From page 2 instructions; do not use medical terms or abbreviations." During an interview with LN# 14 on 12/4/14 at 4:00 PM, he stated, " I reviewed the medication list with the resident before discharge." On 12/4/14 at 4:45 PM, the Administrator and the DON were informed of the above finding. The facility provided no new additional information.	F 204	F-241 SPECIFIC RESIDENT Resident #19 is covered appropriately when transporting to and from the shower in order to ensure privacy and dignity. CNA #6 was educated to ensure all residents are appropriately covered.		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure dignity was maintained when a resident's bottom was exposed while being transported from the shower room to the bedroom. This was true for 1 of 3 (#19) random residents. The deficient practice had the potential for harm if residents became embarrassed when appearing in public after a shower without being properly covered. Findings included: On 12/2/14 at 1:32 p.m., Resident #19 was observed seated in a shower chair wearing a short sleeve top with a blanket draped over her lap. The blanket was not tucked in around the resident and her bottom was exposed. The resident was transported from the shower room	F 241	OTHER RESIDENTS Residents will remain covered during transport to and from the shower room to ensure privacy. SYSTEMIC CHANGES Root cause indicates that CNA #6 failed to execute the appropriate process. CNA's educated to ensure the appropriate execution of process on adequately covering residents to ensure dignity and privacy when in a public area. When transporting residents from the shower room to their rooms, the resident will be dressed in the shower room when possible, and if they must be covered with a bath blanket during transport, the blanket is to be tucked around them providing privacy and comfort.		

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F 241	Continued From page 3 and down the hall to her room with multiple people at the nurse's station near the shower room and another resident in the hallway. Once the resident was in her room, CNA #6 was asked about transporting a resident in a shower chair without properly covering the resident. The CNA acknowledged the resident was not entirely covered after observing the exposed areas herself and said the blanket would usually be tucked in. On 12/3/14 at 3:15 p.m., the DON was asked about the process for ensuring privacy during transportation after a shower and she said the resident would need to be covered to maintain privacy when going from the shower room to the resident's room. On 12/3/14 at 6:35 p.m., the Administrator and DON were informed of the dignity issue. No further information was provided.	F 241	MONITOR Resident Care Manager's will monitor showers transports to ensure that appropriate execution of process occurs and there are no residents exposed in public areas. DON or designee will perform routine audits of residents for dignity concerns. Audits will be taken to monthly QA meeting and changes will be implemented as necessary. COMPLIANCE DATE: 1/7/15		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	F-280 SPECIFIC RESIDENT Resident #1's Care plan was reviewed and updated to include geri-sleeves and clarification provided for the transfer status as 2 person assist with hoyer for all transfers. Resident # 10's care plan was reviewed and updated to include built up utensils and lipped plate. OTHER RESIDENTS Care plans and tray cards were reviewed and updated for accuracy and to ensure that geri-sleeves, built up utensils, lipped plates and 2 person		

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F 280	<p>Continued From page 4</p> <p>the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to update/revise care plans for 2 of 10 sample residents (#s 1 and 10). The failure created the potential for more than minimal harm when care plans did not reflect the residents' current status to ensure appropriate provision of care for transfers and geri-sleeves to the legs for Resident #1 and built-up utensils and a lip plate for Resident #10. Findings included: 1. Resident #1 was admitted to the facility in 2012 and readmitted 6/27/13 with multiple diagnoses which included dementia. The resident's 11/5/14 quarterly MDS assessment coding included short- and long-term memory problems, moderate cognitive impairment, and extensive assistance for transfers and dressing. The resident's recapitulation of Physician Orders for December 2014 included a 9/22/14 order for geri-sleeves to both lower extremities at all times. The resident's 5/13/13 skin care plan did not include the intervention for geri-sleeves to both lower extremities at all times. The resident's 5/13/14 care plan also contained 2 different interventions for transfers. The self-care deficit interventions included, "Transfer with 2 ext. [extensive] assist with shower and transfer." And, fall interventions included, "11-5-14 Hoyer [brand</p>	F 280	<p>Hoyer transfers are care planned as indicated.</p> <p>SYSTEMIC CHANGES</p> <p>Root cause indicated failure to execute the process to update care plans when a lipped plate, built up utensils, geri-sleeves or 2 person Hoyer transfer status changes. Education was provided to Interdisciplinary Team on execution of the process to ensure that the care plan and interventions are updated when adding geri-sleeves, lipped plate, built up silverware or 2 person Hoyer transfer status in a timely manner.</p> <p>MONITOR</p> <p>DON or designee will perform audits to ensure care plans are updated in a timely manner that result in geri-sleeves, lipped plate, built up silverware or 2 person Hoyer transfer status requirements.</p> <p>Audits will be taken to monthly QA meetings to review and action will be taken as necessary.</p> <p>COMPLIANCE DATE: 1/7/15</p>	

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F 280	<p>Continued From page 5</p> <p>of medical equipment] lift for transfers." On 12/3/14 at 9:55 a.m., the DON and Regional Nurse were asked about the leg geri-sleeves and transfers for the resident. The DON reviewed the physician orders for geri sleeves on the lower extremities and stated, "It should be on the care plan." She also reviewed the 2 different care planned interventions for transfers and stated, "Extensive assistance of 2 should have been DC'd [discontinued] when Hoyer transfer was implemented."</p> <p>2. Resident #10 was readmitted to the facility on 8/22/14, with multiple diagnosis including diabetes mellitus, Type II.</p> <p>The resident's Nutrition Care Plan, dated 11/4/11, did not document built-up utensils or lip plate as an intervention.</p> <p>On 12/3/14 at 12:30 PM, the resident was observed with built up utensils and a lip plate during his lunch meal.</p> <p>The resident's tray meal card for 12/3/14, documented the resident was to have built-up utensils and a lip plate.</p> <p>On 12/4/14 at 12:00 PM, the DON was interviewed regarding the care plan. When informed the built-up utensils and lip plate were not on the care plan, the DON acknowledged it and stated, "I believe you."</p> <p>On 12/4/14 at 4:50 PM, the Administrator, DON, and Regional Nurse were informed of the care plan issues. No further information was provided by the facility.</p>	F 280		

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F 309 F 309 SS=D	Continued From page 6 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to implement care-planned interventions for geri-sleeves to both upper extremities (arms) for 1 of 10 sample residents (#1). The failure created the potential for skin problems, such as tears and bruises, when the resident's arms were not protected. Finding included: Resident #1 was admitted to the facility in 2012 and readmitted 6/27/13 with multiple diagnoses which included dementia. The resident's 11/5/14 quarterly MDS assessment coding included short and long term memory problems, moderate cognitive impairment, and extensive assistance for dressing. The resident's 5/13/13 skin care plan included the intervention, "Geri-sleeves to both upper extremities at all times except when providing cares, showers, skin checks..." The resident was observed without geri-sleeves on her upper extremities on 12/2/14 at 8:30 a.m., 8:45 a.m., and 9:40 a.m., On 12/2/14 at 10:00 a.m., CNA #4 was asked if	F 309 F 309	F-309 SPECIFIC RESIDENT Resident #1's care plan was reviewed and associates educated to review care plans and ensure interventions are implemented. Resident #1's geri sleeves are in place in accordance to the care plan. OTHER RESIDENTS Residents with geri-sleeves ordered were reviewed to ensure they are in place as ordered. SYSTEMIC CHANGES Root cause indicated staff education and execution of process to review and implement care plan/care guides. Education provided relating to updating and implementing care plans. CN A's are to review their daily care guides to know what care planned interventions need to be in place. MONITOR DON or designee will audit to observe that Residents care planned interventions are in place as appropriate. Audits will be taken to the monthly QA committee and changes will be implemented as necessary. COMPLIANCE DATE: 1/7/15		

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F 309	Continued From page 7 geri-sleeves should be on the resident's arms. The CNA stated, "She does not wear them on her arms, just her legs." The resident was observed again without geri-sleeves on her arms on 12/2/14 at 12:15 p.m. and 3:20 p.m. On 12/3/14 at 9:55 a.m., the DON and Regional Nurse were informed of the aforementioned observations and asked about the resident's care plan for geri-sleeves to both upper extremities. The DON said she would look at the care plan and get back with the surveyor. On 12/3/14 at 10:30 a.m., the DON confirmed that the resident's care plan for geri-sleeves to both upper extremities at all times except when providing cares, showers, and skin checks was not followed.	F 309	F-323 SPECIFIC RESIDENT 1. All hoyer lifts, walkers, hydration cart, ice chests, linen carts, tray cart, power chair, wheelchairs and blood pressure machines mentioned were removed to ensure hallways were cleared for safe resident transit and handrails were accessible for use. 2. Water temperatures in rooms 108, 214, 320 were adjusted and temped on both 12/4 and 12/5 and were below 120 degrees F.		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure equipment did not block access to handrails or exits, and failed to ensure water temperatures were within a safe range in resident rooms. This was true for 14 of 14 (#s 1-14) sampled residents, any mobile resident, and 3 resident rooms. These failures	F 323	OTHER RESIDENTS 1. All other areas of the hallways monitored and no Hoyer lifts, walkers, hydration cart, ice chests, linen carts, tray cart, power chair, wheelchairs or blood pressure machines were found obstructing passage or handrail use. 2. The water mixer valve was adjusted in the control room and water temperatures were audited throughout the facility with no temperature reading above 120.0 degrees F. SYSTEMIC CHANGES 1. Root cause indicated facility designation of storage and staff education on ensuring access to handrails are not blocked by equipment when they are not in use. Education		

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F 323	<p>Continued From page 8</p> <p>created the potential for injury should residents trip and fall when unable to access handrails blocked by equipment not in use, should residents be unable to get through a blocked exit door on A-Wing by lift equipment, and should residents sustain burns related to high water temperatures. Findings included:</p> <p>1. On 12/1/14 the following observations were made of equipment not in use blocking handrails on A-Wing and D-Wing: * From 11:20 a.m. until 2:30 p.m., a hoier lift was parked between rooms 309 and 310, and a 4 wheel walker (4WW) was parked outside of room 311; and, * At 2:32 p.m., a hoier lift was parked between room 316 and the D-Wing Nurse Unit Manager's office.</p> <p>On 12/1/14 from 1:25 PM to 1:55 PM and on 12/2/14 from 8:02 AM to 3:25 PM the following observations were made of the A wing hallways: * On nine different occasions the handrails between Electrical Room 3 and the drinking fountain were observed to be blocked by one of the following: a hydration cart, ice chest, linen cart, tray cart, and/or a blood pressure machine on wheels; and, * On seven different occasions the handrails between resident rooms 211 and 212 were observed to be blocked by a linen cart.</p> <p>On 12/ 1/14 from 8:50 AM to 2:21 PM and on 12/3/14 from 10:20 AM to 12:30 PM the following observation were mad of the D wing hallways: *On seven different occasions the handrails across from the nursing station and next to an unmarked door were observed to be blocked by the vital sign and hydration carts and,</p>	F 323	<p>provided to staff that all machines, carts, mobility devices, etc must be stored in the designated area out of the hallway. An additional storage area was designated.</p> <p>2. Root cause indicated Maintenance staff education and execution of process to assure the mixing valve is adjusted to a water temp to assure fluctuations in temp are kept below 120. Water mixing valve adjusted to lower temperature and specialist came in to assess performance of current equipment. Education provided to the maintenance workers who check the water temperatures to assure that the mixing valve is adjusted at a temperature that keeps any fluctuations in temp below 120.0 degrees F.</p> <p>MONITOR Executive Director or designee will perform audits to ensure hallways are properly cleared and handrails accessible. Audits on water temperatures will be performed by the Maintenance Director and reviewed by the Executive Director or designee.</p> <p>Audits will be taken to monthly QA meetings to review and action will be taken as necessary.</p> <p>COMPLIANCE DATE: 1/7/15</p>

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F 323	<p>Continued From page 9</p> <p>* On six different occasions the handrails between room 319 and the activity room were blocked by a chair and 2 power chairs; and, * On six different occasions the handrails outside of room 318 and accross from the acitivity room were blocked by a walker with armrest.</p> <p>On four different occasions an entire wall of handrails along the short hallway across from the Business Office was blocked with wheelchairs: On 12/1/14 at 1:18 PM- 3 wheelchairs; On 12/2/14 at 8:41 AM and 2:21 PM- 5 wheelchairs; and, On 12/3/14 at 10:47 AM- 4 wheelchairs.</p> <p>On 12/3/14 at 10:47 AM, Resident #10 was observed trying to make his way down the hallway across from the private dining room and towards the Business Office. The resident had difficult manuevering past the wheelchairs (4) on the other side of the hallway.</p> <p>On 12/3/14 at 2:55 p.m., CNA #9 said there was a specific area for equipment to be stored when not in use in the hallways and there was also a room on D-Wing with cushions. When asked if equipment was supposed to be stored in hallways, the CNA stated, "No."</p> <p>On 12/3/14 at 2:57 p.m., LPN #10 said equipment not in use, "Should be in the clean utility room," and hoyer lifts were put into the storage room.</p> <p>On 12/3/14 at 2:58 p.m., CNA #11 stated, "Hoyers are stored in the hallways."</p> <p>2. On 12/4/14, during a tour of the facility</p>	F 323		

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F 323	Continued From page 10 environment with the Maintenance Director, the Administrator, and the DON, high water temperatures were noted in resident room bathroom sinks as follows: 10:55 a.m., room 108 was 121.3 degrees Fahrenheit (F); 11:00 a.m., room 214 was 120.2 F; and, 11:20 a.m., room 320 was 122.3 F. Resident rooms 108 and 214 were not occupied at the time; however, room 320 was. When asked if the resident in room 320 used the bathroom sink, the DON stated, "Yes." The Maintenance Director used a "brand new" facility thermometer to check the water temperatures; and, after each check, the Maintenance Director acknowledged the aforementioned water temperatures were higher than 120 F. The Maintenance Director said the temperature at the water mixer valve had been set at 118 F and none of the temperatures should have been higher than 118 F. The Maintenance Director said he would lower the temperature at the mixer valve and recheck the water temperatures 20 minutes after that. In the afternoon on 12/4/14, the Maintenance Director and the Administrator both provided recheck water temperature documentation which showed the water temperatures were less than 120 F.	F 323	F-325 SPECIFIC RESIDENT Resident received a dietary consultation on 12/03/14 OTHER RESIDENTS All other residents reviewed for any outstanding dietary consultation requests and none were found. SYSTEMIC CHANGES Nursing, physician or resident requests for dietary consultations will be given to the DON or designee who will track the request until completed. DON, dietary manager and RD were re-educated on the procedure for completion of dietary consultations. MONITOR DON or designee will perform audits to ensure dietary consultations are completed timely. Audits will be taken to monthly QA meetings to review and action will be taken as necessary. COMPLIANCE DATE: 1/7/15		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325			

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F 325	<p>Continued From page 11</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident's weight gain was assessed to determine possible cause. This was true for 1 of 1 resident (#4) sampled for weight status. This practice created the potential for untreated medical conditions related to the resident's weight gain. Findings included:</p> <p>Resident #4 was admitted to the facility on 6/10/14 with diagnoses of congestive heart failure, COPD, and depressive disorder.</p> <p>On admission Resident #4's weight was 195 lbs. (pounds) and she was provided with a regular diet. The resident's last weight prior to survey was documented as 238 lbs. on 11/25/14.</p> <p>An 8/25/14 physician's order documented, "Furosemide 40 MG tablet, take 1 and 1/2 tablets [60 MG] PO [by mouth] BID [twice a day]," in addition to Spironolactone 25 MG daily that Resident #4 was receiving. The next day, 8/26/14, Resident #4's weight was documented as 231 lbs., a gain of 36 lbs since admission.</p> <p>On 9/3/14 Resident #4's weight was documented as 211 lbs, a loss of 20 lbs. At that time, the resident was put on the facilities RAR (Residents at Risk) program for significant weight loss. In addition, there was a change to the resident's diet</p>	F 325			

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F 325	<p>Continued From page 12 to fortified cereal and soup, and 2 snacks a day.</p> <p>On 9/9/14 the resident's weight was documented as 215 lbs a gain of 4 lbs. from her 8/26/14 weight. She continued to gain weight and on 11/05/14 her weight was documented as 235 lbs.</p> <p>On 11/7/14 at 8:01 AM, a progress notes E-signed by LN #5 documented, "Spoke with her [Resident #4] about her wt [weight] loss and if it [was] desired, she said yes. She would like to see the dietician for a wt [weight] reduction plan."</p> <p>During an interview on 12/3/14 at 4:08 PM, LN #5 stated, "On 11/7/14 an Interdisciplinary Communication/Referral was submitted to the dietary department for a consult with the RD for a possible weight management plan, and the RD is meeting with the resident today [12/3/14]."</p> <p>On 12/4/14 at 2:25 PM, during an interview with the RD related to why Resident #4's consult didn't happen until 12/3/14, she stated, "I remember seeing the consult, not sure the date. I prioritize needs and care for immediate needs, weight loss. I looked at her chart with her fluctuating weight with fluid retention. She was given fortified food and 2 snacks daily when she lost weight. She was on my list to see on 12/3/14 when the RCM [Resident Care Manager] brought it to my attention. I will look at all charts for trending so no one gets over looked."</p> <p>The Nutritional Progress Notes dated, 12/3/14, documented a consult between the RD and Resident #4. The RD documented, "Res [resident] does not need extra Kal [calories]. Rec [recommend] D/C [discontinue] snacks and fortified foods to limit excess Kal intake/wt gain."</p>	F 325			

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F 328	<p>Continued From page 14</p> <p>disease (COPD). The resident's significant change MDS assessment, dated 11/10/14, coding included severe cognitive impairment and use of O2. The resident's recapitulation of Physician Orders for December 2014 included a 2011 order for O2 at 2 liters per minute via nasal cannula continuously for COPD. The resident's care plan included the problem "COPD- oxygen use." Interventions included, "Administer/observe effectiveness of treatments (see current physician's order) * Oxygen- per MDO [physician order]...Dislodges O2 tubing often, monitor for proper placement." On 12/3/14 at 10:55 a.m., the resident was not in her room. However, an O2 companion tank was observed on the floor just inside the door to the room and an O2 nasal cannula (NC) was on the resident's bed. On 12/3/14 at 10:56 a.m., the resident was observed in the 400 hall dining room at a table with 2 other residents. The resident was not wearing her O2 NC and an O2 companion tank was not on the back of her wheelchair. And, the surveyor did not observe an O2 companion tank anywhere near the resident. On 12/3/14 at 10:57 a.m., RCM #5 accompanied the surveyor to the 400 hall dining room. When asked about the resident's O2, the RCM acknowledged that the resident's O2 NC and companion tank were not in place. The RCM went directly to the resident's room and retrieved the O2 NC and companion tank. On the way back to the dining room, CNA #3 said to the RCM, "I wasn't the one who got her up today!" The RCM applied the resident's NC and started the O2-companion tank at 2 liters per minute.</p> <p>2. Resident #3 was admitted to the facility on</p>	F 328	<p>place as ordered and there are parameters for PRN oxygen use.</p> <p>Audits will be taken to the monthly QA meeting and changes will be implemented as necessary.</p> <p>COMPLIANCE DATE: 1/7/15</p>		

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F 328	Continued From page 15 9/30/14 with multiple diagnoses including atrial fibrillation. The resident's 9/30/14 Respiratory Care Plan documented an intervention of, "O2 [oxygen] per MD order." The resident's 10/24/14 Physician Orders documented, "O2 to keep saturation[s] [at or greater than] 92%." Note: The order did not contain specific parameters for the flow rate to be set. The resident's October and November TAR documented the resident received oxygen at 1.5 and 2 liters per minute per nasal cannula. On 12/3/14 at 4:15 PM, RCM #7 was interviewed regarding the resident's oxygen. The RCM was shown the physician order and then asked if it contained the liter flow. She said, "It doesn't." She then said, "I will get it clarified." On 12/4/14 at 4:50 PM, the Administrator, DON, and Regional Nurse were informed of the oxygen issues. No further information was provided by the facility. On 12/8/14 the facility sent additional documentation via email, however the information provided did not resolve the concerns.	F 328	F-329 SPECIFIC RESIDENT Resident # 5 has all appropriate behavior tracking records in place, including audio hallucinations and picking behaviors. OTHER RESIDENTS Residents on psychotropic medications audited to ensure all behavior tracking records are in place. SYSTEMIC CHANGES Root cause indicated facility process with creation and implementation in order to communicate to nursing the need to track behaviors. Behavior tracking system updated to designate Social Services to implement behavior tracking as appropriate and designate at that time for nursing to complete the behavior tracking. Education provided to Social Service Staff, Nurse Management and Nursing staff on process of creation, implementation and importance of tracking behaviors.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329	MONITOR DON or designee will audit to ensure residents who are on a psychotropic medication have the correct target behavior monitoring in place.	

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F 329	<p>Continued From page 16</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behaviors were adequately monitored for the use of an antipsychotic medication. This was true for 1 of 4 (#5) sampled residents reviewed for antipsychotic medication use. This practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>Resident #5 was admitted to the facility on 11/7/12 with multiple diagnoses which included schizophrenia and obsessive compulsive disorder.</p>	F 329	<p>Audits will be taken to the monthly QA meeting and changes will be implemented as necessary.</p> <p>COMPLIANCE DATE: 1/7/15</p>		

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F 329	<p>Continued From page 17</p> <p>The most recent annual MDS assessment, dated 10/25/14, documented Resident #5 was cognitively intact with a BIMS of 15, did not display any behaviors and received an antipsychotic medication 7 out of 7 days.</p> <p>Resident #5's Psychotropic Meds Care Plan, dated 11/26/12, documented the resident had an alteration in mood and behavior related to a diagnosis of Schizophrenia, insomnia and depression. The resident exhibited behaviors of decreased appetite, feelings of despair, audio hallucinations, delusions, harm to self or others and picking at skin. A goal included the resident would have no signs and symptoms of schizophrenia or delusions. Interventions included discussion related to side effects of psychotropic medications, observing for adverse side effects and encouraging the resident to express feelings.</p> <p>The Care Plan did not instruct staff to monitor behaviors of audio hallucinations, delusions or picking at skin.</p> <p>The December 2014 recapitulated Physician's Orders documented an order for Resident #5 to receive Risperdal 0.5 mg every night for bipolar with psychotic features as indicated by audio hallucination and harm to self picking and scratching skin, with a start date of 9/17/13.</p> <p>The Behavior/Intervention Monthly Flow Record for September and October 2014 documented the behaviors monitored were decreased appetite, feelings of despair, and hours of sleep. The records did not document audio hallucinations or picking at skin behaviors for Resident #5, which were treated with the antipsychotic Risperdal.</p>	F 329		

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F 329	Continued From page 18 A Psychotropic/Behavior Management Summary, dated 10/16/14, documented Resident #5 had no episodes of audio hallucinations and/or picking at skin. On 12/3/14 at 1:45 p.m., the DON was interviewed with the Regional Nurse and LN #5 present. The DON was asked if hallucinations and picking behaviors were monitored for Resident #5 in September and October 2014. After reviewing the behavior monitors she stated, "Not on these ones." LN #5 left the room to look for additional information. The DON said the nurse manager who does recap orders had been doing behavior sheets, but Social Services took over to ensure accuracy after the facility identified there was an issue with the behavior monitoring process. LN #5 returned to the room and reported additional information was not found. On 12/3/14 at 2:49 p.m., Social Worker (SW) #12 was asked how it was determined Resident #5 had no episodes of hallucinations or picking behaviors when those behaviors were not monitored in September and October 2014. The SW said, "That's a good question," and the information used for the Psychotropic/Behavior Management Summary in October 2014 would have come from September 2014's monitors. The SW said she would look into the matter. On 12/3/14 at 3:04 p.m., SW #12 said she was unable to find additional information regarding Resident #5's behavior monitoring. Resident #5's audio hallucinations and picking behaviors were not monitored for 2 consecutive months. The Psychotropic/Behavior Management	F 329		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815	
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F 329	Continued From page 19 Summary documented zero episodes of those behaviors. It is unclear how the behavior information was determined when the behaviors were not monitored.	F 329	F-356 SPECIFIC RESIDENT No specific resident was affected by this.	
F 356 SS=C	On 12/3/14 at 6:35 p.m., the Administrator and DON were informed of the behavior monitoring concern. No further information was provided. 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356	OTHER RESIDENTS All residents had potential to be affected by this. SYSTEMIC CHANGES Root cause indicated facility process of designating appropriate staff to update staffing board daily. The staffing coordinator or designee has been specifically assigned to review the daily hours for CNA, RN, and LPN and update the board daily with the census. Facility has educated staffing coordinator of the importance of updating the staffing board daily. MONITOR DON or designee will audit the staffing board to ensure it is updated daily. Audits will be taken to the monthly QA meeting and changes implemented as necessary. COMPLIANCE DATE: 1/7/15	

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F 356	Continued From page 20 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to display the correct information on the nurse staff posting for residents and visitors. This affected 14 of 14 (#s 1-14) sampled residents and had the potential to affect all residents who resided in the facility and any visitors who came to the facility. Findings included: On 12/1/14 at 2:00 PM, the nurse staffing was posted on the wall near the front entrance, however, the date of the information was listed as 11/20/14. On 12/1/14 at 2:01 PM, the Administrator was asked about the posting and he stated, "The date is wrong." He acknowledged the information posted was for 11/20/14 and had not been updated for 11 days. He said he would make sure it was updated. On 12/2/14 at 8:00 AM, the nurse staffing posting was observed with the current date and current staffing and current census information.	F 356	F-369 SPECIFIC RESIDENT Resident #10 is provided with built up utensils and a lipped plate for all meals. OTHER RESIDENTS All residents who have adaptive equipment care planned was audited to ensure that they are provided during meals. SYSTEMIC CHANGES Root cause indicated Execution of process with dietary staff identifying the need and placing adaptive utensils in accordance to the tray card on the tray line and nursing staff to review tray card to assure adaptive utensils are on the tray upon delivery. Dietary staff educated on execution of the process of review for adaptive equipment on the tray card during tray line to ensure the adaptive equipment is provided. Nursing staff educated to pay close attention to the meal tray card and to ensure adaptive utensils for all meals are provided.		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced	F 369	MONITOR Dietary manager to audit tray line to assure dietary staff execute the process of placing adaptive equipment on the tray during tray line.		

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F 369	<p>Continued From page 21</p> <p>by: Based on observation, record review, and resident and staff interview, it was determined the facility did not provide special eating equipment for a resident who needed it. This was true for 1 of 14 sampled residents (#10). This deficient practice had the potential to harm the resident if his nutritional status declined. Findings included:</p> <p>Resident #10 was readmitted to the facility on 8/22/14, with multiple diagnoses including diabetes mellitus, Type II.</p> <p>On 12/2/14 at 8:15 AM, during a breakfast observation, the resident was observed to use built-up utensils with a regular dinner plate.</p> <p>At 12:12 PM, during the lunch observation, the resident was observed to use built-up utensils with a regular plate. The resident's chicken cordon bleu was observed to partially slide off his regular dinner plate as he attempted to use the fork to cut into the chicken. When the resident was asked about his regular plate and built-up utensils, he said the utensils were a great help and the lack of a lipped plate was not a big concern to him. The resident's tray meal card documented the resident was to receive a lip plate and built-up utensils for all meals.</p> <p>On 12/3/14 at 6:10 PM, during the dinner meal observation, the resident was observed to use a lip plate with regular utensils. He appeared to struggle to pick up the noodle casserole with his regular spoon.</p> <p>On 12/4/14 at 9:00 AM, the Food Service Supervisor (FSS) was interviewed regarding the observations. When asked why the resident did</p>	F 369	<p>Unit managers will audit meal tray cards and resident's meal set up to ensure recommended adaptive equipment is in place.</p> <p>COMPLIANCE DATE: 1/7/15</p>	

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F 369	Continued From page 22 not receive the lip plate for breakfast and lunch, he stated, "I'm guessing it just slipped through the system." When asked why he did not receive the built-up utensils for dinner, the FSS said they were training a new kitchen staff member and stated, "We missed it." On 12/4/14 at 4:50 PM, the Administrator, DON, and Regional Nurse were informed of the assistive eating device issue. No further information was provided by the facility.	F 369	F-371 SPECIFIC RESIDENT No specific resident involved. Dietary manager started using a net to cover his facial hair on 12/3/14. OTHER RESIDENTS All potential residents have the potential for being affected. SYSTEMIC CHANGES	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. This affected 14 of 14 sample residents (#s 1-14) and had the potential to affect all residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease causing pathogens. Findings included: On 12/2/14 at 9:05 AM, the Food Services	F 371	Root cause indicated Staff education with dietary manager on specifics of the 2009 FDA Food Code with regards to covering beards. Inservice to all kitchen staff to educate on 2009 FDA food code that hair nets and other hair guards are to be worn at all times in the kitchen. MONITOR Executive Director or designee will monitor compliance by all kitchen staff members. The results of the audits will be taken to the monthly Quality Assurance meetings for review and action taken as necessary. COMPLIANCE DATE: 1/7/15	

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F 371	<p>Continued From page 23</p> <p>Supervisor (FSS) was observed walking through the kitchen without a facial restraint to cover his goatee beard, which was approximately 1 to 2 inches in length. Cook #1 was asked how far staff or visitors could come into the kitchen without a hair restraint and he pointed to a half wall attached to a counter in the front part of the kitchen. The FSS was beyond the half wall.</p> <p>On 12/2/14 from 11:12 to 11:22 AM, during the observation of food temperatures, the FSS was observed in the kitchen without a beard restraint. He was observed covering food with lids on the steam table, after Cook #1 recorded food temperatures. When asked about his lack of a beard restraint, he said he had never used one before and stated, "I was not cooking." The surveyor stated he was standing beyond the half wall and the FSS said he would start wearing a restraint.</p> <p>The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles."</p>	F 371			

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F 371	Continued From page 24	F 371	F-441 SPECIFIC RESIDENT	
F 441 SS=D	<p>On 12/3/14 at 11:50 AM, the FSS was observed pushing tray carts from the kitchen and into the hallway with a beard restraint covering his facial hair.</p> <p>On 12/2/14 at 4:05 PM, the Administrator, DON, and Regional Nurse were informed of the issues. No further information was provided by the facility.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p>	F 441	<p>Resident #7 privacy bag for her Foley catheter was changed from a canvas bag to a vinyl bag with a shortened strap to keep it from touching the floor.</p> <p>Resident # 1 had potential for infection due to CNA #4 not performing hand hygiene after incontinence care. Resident has not shown any signs of infection.</p> <p>Resident # 20 refuses to keep his urinal in the bathroom or the bedside stand, he prefers to have it on his bedside table. Education provided to resident regarding infection control and the potential for cross contamination with his drinks and care plan updated.</p> <p>OTHER RESIDENTS</p> <p>All residents with urinary drainage bags were audited to ensure the privacy covers holding the drainage bag are not touching the floor. Residents who have an indwelling catheter and also require the use of a low positioned wheelchair, will have a vinyl privacy bag placed on the chair, off the floor. CNA #4 and other Nursing staff educated about hand hygiene after removal of contaminated gloves.</p> <p>Audit completed of all rooms for any urinals on bedside tables and to ensure urinals are kept in the appropriate place to prevent the transmission of infection.</p>	

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F 441	<p>Continued From page 25</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure a cloth privacy bag with a urinary drainage bag inside did not touch or drag on the floor, hand hygiene was performed after incontinence care, and a urinal was not kept next to drinking containers. These failures affected 2 of 10 sample residents (#s 1 and 7) and 1 random resident (#20) and increased the potential for those residents to develop infections from cross-contamination. Findings included: 1. Resident #7 was admitted to the facility in 2012 with multiple diagnoses which included neurogenic bladder. The resident's 11/15/14 quarterly MDS assessment coded moderate cognitive impairment, total assistance of 2 people for transfers, indwelling urinary catheter, and wheelchair (w/c) in use. The December 2014 recapitulation of Physician Orders included an 11/13/13 order to change the resident's Foley [brand of indwelling urinary catheter] monthly and as needed. The resident's cloth privacy bag with a urinary drainage bag inside was observed as it was in</p>	F 441	<p>SYSTEMIC CHANGES</p> <p>Root cause indicated policy and staff education on appropriate use of privacy bags with residents who have limited distance between the seat of the wheel chair and the floor. Policy addendum for residents who have limited distance between the seat of the wheel chair and the floor due to short stature will have a vinyl privacy bag for catheters. Nursing staff educated on the policy.</p> <p>Root Cause regarding CNA #4 washing hands indicated execution of process. Education provided to CNA's on washing hands to include return demonstration on execution completed.</p> <p>Root cause on LN #10 indicated staff education. LN #10 and Nursing Staff educated regarding the potential for cross contamination if keeping a urinal on bedside table with drinks. Nursing staff are to remove the urinal, empty and clean the urinal, and sanitize the table. If a resident prefers to keep it on the table, they must notify the nurse manager to provide additional education to the resident and attempt to store the urinal in a more sanitary way.</p> <p>MONITOR</p> <p>DON or designee to audit privacy bags to ensure the privacy covers holding the drainage bag are not touching the floor and wheel chairs with limited distance between the seat of the wheel chair and</p>		

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F 441	Continued From page 26 contact with or drug on the floor on 12/1/14 at 1:10 p.m.; 12/2/14 at 8:20 a.m., 8:25 a.m., 9:20 a.m., 9:50 a.m., 11:58 a.m., 12:35 p.m., 1:25 p.m., and 3:25 p.m.; and, 12/3/14 at 10:40 a.m. On 12/2/14 at 8:25 a.m., the privacy bag with the urinary drainage bag inside was observed to drag on the floor as CNA #3 wheeled the resident from the 400 hall dining room approximately 50 feet to her room. Immediately afterward, CNA #3 was asked about the privacy bag in contact with the floor. The CNA looked at the privacy bag then stated, "It's as high as we can get it because her wheelchair is so low." On 12/2/14 at 12:35 p.m., the privacy bag with the urinary drainage bag inside was again observed to drag on the floor as CNA #8 wheeled the resident from the 400 hall dining room approximately 50 feet to her room. On 12/3/14 at 10:40 a.m., the resident was observed in her w/c by her bed. The resident's privacy bag with the urinary drainage bag inside was observed in contact with the floor under the w/c. On 12/3/14 at 10:50 a.m., RCM #5 was asked to accompany the surveyor to the resident's room. Once in the resident's room, the RCM was asked about the urinary privacy bag in contact with the floor, which the RCM acknowledged. When asked if the cloth privacy bag was impermeable, the RCM indicated that it was not. When asked if it was an infection control issue, the RCM stated, "Yes it is!" The RCM raised the cloth urinary privacy bag higher up on the resident's w/c, which suspended it off the floor. On 12/4/14 at 10:20 a.m., the Infection Control Nurse (ICN) was informed of the aforementioned observations of the resident's cloth privacy bag with the urinary drainage bag inside that had been in contact with- and drug over the floor. The	F 441	the floor due to short stature will have a vinyl privacy bag for catheters. Unit Managers will conduct hand hygiene audits to ensure execution of proper hand hygiene completed after the removal of gloves and audit of male rooms to ensure urinals are properly stored. Audits will be taken to the monthly QA meeting and changes implemented as necessary. COMPLIANCE DATE: 1/7/15	

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F 441	<p>Continued From page 27</p> <p>ICN exclaimed "Oh no!" When asked if urinary privacy bags were impermeable, the ICN said, "They are made out of canvas." When informed the resident's privacy bag was not made of canvas, the ICN said, "That's the problem, we use different kinds." The ICN was asked to provide the facility's policy regarding the care of urinary drainage bags.</p> <p>On 12/4/14 at 11:30 a.m., the ICN provided a partial Genitourinary policy which documented, "Make sure the catheter tubing and drainage bag are kept off the floor." The ICN indicated the facility did not have a specific policy regarding privacy bags.</p> <p>2. Resident #1 was admitted to the facility in 2012 and readmitted 6/27/13 with multiple diagnoses which included dementia, severe colitis, history of cerebrovascular accident (stroke), and recurrent urinary tract infections.</p> <p>On 12/2/14 at 9:40 a.m., CNA #3 and CNA #4 were observed as they provided incontinence care and incontinence brief change for the resident. After that, CNA #4 removed her gloves. However, the CNA did not perform any type of hand hygiene before she handled the resident's bed control and TV (television) remote control bare handed then picked up a trash bag and left the resident's room.</p> <p>Immediately afterward, CNA #4 was interviewed. When informed of the observation and lack of hand hygiene, the CNA stated, "I know I should have but I had those things in my hands." The CNA then washed her hands.</p> <p>3. On 12/3/14 at 4:32 p.m., LN #10 was observed to administer medications to Resident #20. The resident's bedside table was next to him with a urinal next to a water cup with a straw and a water pitcher. The LN moved the bedside table to</p>	F 441			

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F 441	<p>Continued From page 28</p> <p>turn on the light per Resident #20's request, put the bedside table back where it had been, and left the room. The LN did not move the urinal or sanitize the bedside table.</p> <p>On 12/4/14 at 8:23 a.m., the DON, with the Infection Control Nurse present, was asked where urinals were to be kept in a resident's room and she stated, "Not on the bedside table, not next to water." Residents could keep the urinals on a stand next to the bed if no fluids were present, or they would be kept in the bathroom. The Infection Control Nurse said if a urinal was on a bedside table, it would need to be moved and the table would need to be disinfected.</p> <p>On 12/4/14 at 4:45 p.m., the Administrator, DON, and Regional Nurse were informed of the infection control issues. The facility did not provide any other information regarding the issues.</p>	F 441			

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey and complaint investigation of your facility. The surveyors who conducted the survey were: Linda Kelly, RN, Team Coordinator; Brad Perry, LSW; Lauren Hoard, RN, BSN; and Judy Atkinson, RN. The survey team entered the facility on 12/1/14 and exited on 12/5/14. Survey Definitions: DON = Director of Nursing CNA = Certified Nurse Aide	C 000	<i>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</i>	1-7-15
C 120	02.100,03,c,iv Appropriate Cause for Transfer/Discharge iv. Is transferred or discharged only for medical reasons, or for his welfare or that of other patients/ residents, or for nonpayment for his stay (except as prohibited by Titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record; This Rule is not met as evidenced by: Please refer to F204 as it relates to discharge medication instructions.	C 120	For citations C120, C125, C325, C445, C644, C672, C782, C784, C787, C788 & C790 please refer to the associated F-tag Plan of Correction. COMPLIANCE DATE: 1/7/15	
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including	C 125		

RECEIVED
JAN - 2 2015
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bryan Lindsay</i>	TITLE Executive Director	(X6) DATE 12-30-14
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STATE FORM 6899 I10Z11 If continuation sheet 1 of 7

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001390	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2014
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 125	Continued From page 1 privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it relates to dignity after showering.	C 125	C268 SPECIFIC RESIDENT No specific resident identified OTHER RESIDENTS All residents have the potential to be affected	
C 268	02.107,01 Dietary Service 107. DIETARY SERVICE. 01. Dietary Supervision. A qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall: This Rule is not met as evidenced by: Based on review of the Food Service Supervisor's (FSS) credentials, record review and staff interview, it was determined the facility did not ensure the FSS completed an approved program for Food Service Supervision. This had the potential to affect 14 of 14 sampled residents (#s 1-14) and all other residents who dined in the facility. Findings included: The Idaho Administrative Code, Department of Health and Welfare, IDAPA (Idaho Administrative Procedures Act) 16.03.02 - Rules and Minimum Standards for Skilled Nursing & Intermediate Care Facilities, sub-section 002.13.a,b,c, & d, defines a Food Service Supervisor as a person who: "a. Is a qualified dietitian; or b. Has a baccalaureate degree with major studies in food and nutrition or food service management; or c. Is a graduate of a state approved Food Service Supervisor's (Dietetic Assistant) course,	C 268	SYSTEMIC CHANGES Dietary manager has enrolled in the next Certified Dietary Manager course (Idaho's ANFP Dietary Manager Online Training Course) starting on 2/23/15. Current dietary manager was hired with 15 years of long-term kitchen management experience. His work is additionally overseen by a licensed dietician who is on site one to two times a week and available by phone the other three or four days. The dietician oversees the clinical aspect of his work and performs audits of all aspects of dietary compliance and reviews all findings with dietary manager. Additional time each week will be scheduled with the RD and the dietary manager to provide education, training, oversight and support until the manager completes the manager training course. A waiver is submitted along with this plan of correction to waive dietary manager qualification requirements until the course is completed. MONITOR Audits of dietary compliance and systems will be performed by the	

Bureau of Facility Standards

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C 268	Continued From page 2 classroom or correspondence; or d. Has training and experience in food service management in military service equivalent in content to program in paragraph c." Upon review of the FSS's credentials, it was determined he did not meet any of the four criteria listed above. On 12/3/14 at 11:55 AM, the Administrator was interviewed regarding the credential issues. He said the facility had recently hired the FSS and that he would be attending the next certification training in February of 2015.	C 268	licensed dietician and reviewed with the dietary manager each week. All concerns will be addressed with the executive director and any repeat concerns will be brought through QAPI. Quarterly oversight audits will be completed by the senior consultants and concerns brought through the facility QAPI process. Audits will be taken to the monthly QA meeting and changes implemented as necessary. COMPLIANCE DATE: 1/7/15	
C 325	02.107,08 Food Sanitation 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 regarding a beard restraint not worn in the kitchen.	C 325		
C 411	02.120,05,k All Resident Rooms Numbered k. All patient/resident rooms shall be numbered. All other rooms shall be numbered or identified as to purpose. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure three rooms were numbered or identified as to their purpose. The failure had the potential for a	C 411		

Bureau of Facility Standards

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C 411	<p>Continued From page 3</p> <p>negative effect for residents who lived in the facility, visitors who came to the facility, and staff who worked in the facility. Findings included:</p> <p>On 12/1/14 at 1:35 p.m., a room across from the 200 Hall Nourishment Station was observed without any numbering or signage regarding its purpose.</p> <p>On 12/1/14 at 1:36 p.m., RCM #7 was asked about the aforementioned unlabeled room. The RCM stated, "That's my office. There's no sign on it is there?"</p> <p>On 12/2/14 at 2:00 p.m., a room across from the D-Wing Nurses' Station was observed without any numbering or signage regarding its purpose. The outside of the door had a "PAML" box attached to it. CNA #3, who was in the vicinity at the time, was asked about the room. The CNA stated, "It used to be the oxygen room until it got moved. Now there's nothing in it." The CNA unlocked the door and the CNA and surveyor both observed a mechanical lift and 2 covered carts stored in the room.</p> <p>On 12/2/14 at 2:10 p.m., a room on the right side just before the double doors onto the 400 hall was observed without any numbering or signage regarding its purpose.</p> <p>On 12/2/14 at 2:15 p.m., Housekeeper #13 was asked about the room just before the double doors onto the 400 hall. She stated, "It's an extra shower room. We don't use it much now."</p> <p>On 12/3/14 at 5:35 p.m., the Administrator, DON, and Regional Nurse were informed about the 4 unnumbered/unidentified rooms. The facility did not provide any other information regarding the</p>	C 411	<p>C-411</p> <p>SPECIFIC Finding Signs for the RCM office, Storage areas, & shower rooms were placed outside their door.</p> <p>OTHER Areas Other doors observed to not have signage indicating their use had signs place outside their door.</p> <p>SYSTEMIC CHANGES Education provided to maintenance staff to replace any sign taken down during remodeling or in repurposing any room or closet.</p> <p>MONITOR Executive Director or designee will audit rooms to ensure they are appropriately labeled.</p> <p>Audits will be taken to the monthly QA meeting and changes implemented as necessary.</p> <p>COMPLIANCE DATE: 1/7/15</p>	
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Bureau of Facility Standards

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C 411	Continued From page 4 issue.	C 411		
C 445	02.120,13,c Hot Water Temps 105-120 Degrees F c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit. This Rule is not met as evidenced by: Refer to F323 as it relates to hot water temperatures.	C 445		
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it related hand hygiene.	C 644		
C 672	02.150,03,c Staff Knowledge of Infection Control c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Refer to F441 as it related to infection control with regards to cloth urinary privacy bag in contact with the floor and a urinal next to drinking containers.	C 672		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed	C 782		

Bureau of Facility Standards

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C 782	Continued From page 5 to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it related to the revision/updating of residents' care plans.	C 782		
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it related to not following care planned interventions for geri-sleeves.	C 784		
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Refer to F369 regarding adaptive eating devices.	C 787		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it related to orders for oxygen.	C 788		

Bureau of Facility Standards

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C 790 C 790	Continued From page 6 02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to preventing accidents.	C 790 C 790		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
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3232 Elder Street
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FAX 208-364-1888

January 16, 2015

Bryan Lindsay, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815-7764

FILE COPY

Provider #: 135122

Dear Mr. Lindsay:

On **December 5, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Coeur d'Alene. Judy Atkinson, RN, Lauren Hoard, RN, Bradley Perry, LSW, and Linda Kelly, RN, conducted the complaint investigation.

The complaint was investigated in conjunction with a second complaint and the facility's Recertification and State Licensure survey conducted from December 1 through December 5, 2014.

The following observations were completed:

- The medication pass was observed;
- Catheter care and the provision of care related to toileting was observed; and
- Staff response to call lights was observed.

The following documents were reviewed:

- The entire medical record of the identified resident;
- Ten other residents' records were reviewed for quality of care concerns;
- The facility's Grievance file from September through December 2014; and,
- Resident Council minutes from October through December 2014.

The following interviews were completed:

- Eleven residents were interviewed during the group interview regarding quality of care and quality of life concerns;

- Four individual residents were interviewed regarding quality of care and quality of life concerns;
- Two residents' family members were interviewed regarding quality of care and quality of life concerns; and,
- Certified Nurse Aides (CNAs) and Licensed Nurses (LNs) were interviewed regarding the provision of resident care.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006722

ALLEGATION #1:

The complainant stated the night shift certified nurse aide (CNA) left the identified resident on the toilet for up to four hours.

FINDINGS:

On December 4, 2014, at 4:00 PM during an interview with a night shift CNA, the CNA stated "The resident was a 2 person assist and sometimes would sit on the toilet on her own. (The resident's name) would want to sit on the toilet for an hour and sometimes for 15 minutes. She liked to read and other things while on the toilet. She was alert and oriented and could make her needs known. When her light went on we would run to get it (answer the light)."

Other residents interviewed during the survey did not express concerns with being left on the toilet for extended periods of time. Commode logs for monitoring on and off of the commode and call light audits did not support that this occurred.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the identified resident had a foley catheter in for approximately one month prior to discharge on October 10, 2014. Twenty minutes prior to that discharge the catheter was removed. The facility did not ensure the resident could void after removing the catheter, and the resident was discharged home.

FINDINGS:

On December 4, 2014 at 3:55 PM, during a telephone interview with the LN who discharged the resident, the LN stated, "The resident went to the bathroom after the foley was taken out and loaded in the van."

On December 5, 2014, multiple written statements were given to the survey team, all affirming that after the resident's foley was removed and before she was discharged home, the resident asked for assistance to the commode to "empty her bladder." One CNA stated, "After she voided, I emptied the commode and finished helping getting her ready for discharge."

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that the LN did not explain to her what times she was supposed to take her medication at home.

FINDINGS:

On October 10, 2014 at 2:44 PM, the discharging LN documented, "Copies of meds (medication list) and discharge information given to resident." The resident's discharge medication list provided instructions on how often to take the medication in medical terms rather than simple understandable terms. The facility's policy documented to, "Include a list of medications with simplified instructions; do not use medical terms or abbreviations."

During an interview on December 4, 2014, at 3:55 PM, the LN stated, "I reviewed the medication list with the resident before discharge."

The facility was cited at F204 for failure to ensure appropriate information was relayed to the resident at the time of discharge.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant stated the identified resident had an order for Gabapentin 300 milligrams (MG) three times a day. The resident received the medication on June 30, 2014, but did not receive it again until July 25, 2014. The resident complained of pain and asked about the medication several times, but got no response. The complainant stated the facility started the resident back on the Gabapentin 300 MG three times a day without gradually increasing the dose.

Bryan Lindsay, Administrator

January 16, 2015

Page 4 of 4

FINDINGS:

The identified resident's record included a physician's order, dated May 28, 2014, for, "Gabapentin 300 MG, give 1 tablet orally at HS (bedtime) for 1 week (5/28-6/3), then...Gabapentin 300 MG, give 1 tablets orally 2 times a day (6/4-6/10), then... Gabapentin 300 MG give 1 tablet 3 times a day times for 1 month (6/11-7/11)." Gabapentin was discontinued on July 11, 2014 with no further complaint of nerve pain. Staff continued to monitor the resident for nerve pain and on July 25, 2014 physician's order stated, "Neurontin (Gabapentin) 300 MG 3 times a day.

When the Medical Director was asked why he didn't gradually increase the dose, he stated it was the lowest recommended dose and he felt it didn't need a gradual increase.

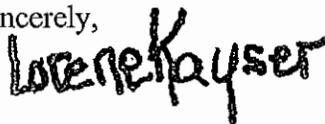
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, LSW, QIDP, Supervisor
Long Term Care

LK/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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January 9, 2015

Bryan K. Lindsay, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815-7764

FILE COPY

Provider #: 135122

Dear Mr. Lindsay:

On December 5, 2014, a Complaint Investigation survey was conducted at Life Care Center of Coeur d'Alene. Linda Kelly, R.N., Bradley Perry, L.S.W., Lauren Hoard, R.N. and Judy Atkinson, R.N. conducted the complaint investigation. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey conducted from December 1 through December 5, 2014.

The following observations were completed:

- The medication pass was observed;
- Residents' linens and bed sheets were observed; and
- Floors in the residents' rooms were observed.

The following documents were reviewed:

- The entire medical record of the identified resident;
- Ten other residents' records were reviewed for quality of care concerns;
- The facility's Grievance file from September through December 2014;
- Resident Council minutes from October through December 2014; and,
- The facility's Allegation of Abuse reports from October through December 2014.

The following interviews were completed:

- Eleven residents were interviewed during the group interview regarding quality of care

- and quality of life concerns;
- Four individual residents were interviewed regarding quality of care and quality of life concerns;
- Two residents' family members were interviewed regarding quality of care and quality of life concerns;
- An identified physician was interviewed regarding filling out a resident's inventory of belongings forms;
- The Director of Nursing was interviewed regarding various quality of care concerns;
- One Resident Care Manager was interviewed regarding medication storage;
- Two nurses were interviewed regarding pain medication administration;
- Five Certified Nurse Aides (CNAs) were interviewed regarding residents' snacks and/or bed linens; and,
- One housekeeper was interviewed regarding mopping routines.

The complaint allegations, findings and conclusions are as follows:

Complaint #6774

ALLEGATION #1:

The complainant stated an identified resident brought medications, which included 80 tablets of an anti-anxiety medication, into the facility on October 24, 2014; the medications were discovered missing sometime after that. The complainant also stated the resident's physician saw the medications when he inventoried the resident's clothes on the personal belongings list. The complainant stated the Director of Nursing (DoN) offered to replace the missing medications, but the identified resident declined the offer to have them replaced. The complainant stated even if the medications would have been replaced, the facility could not replace the narcotics without a handwritten prescription from the physician. The complainant also stated he/she doesn't think the identified resident signed the personal belongings list.

FINDINGS #1:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

The identified resident's inventory sheet, which was signed by the resident and two staff members, did not document any medications were brought into the facility. Two other residents' closed records were reviewed and no concerns were identified.

The identified resident's disposition of unused medication forms were reviewed and found to be signed by the resident on the date of discharge. The forms documented the resident received 85 tablets of an anti-anxiety and 5 tablets of a pain narcotic upon discharge from the facility.

Eleven residents in the group interview did not have a concern with missing medications.

The identified physician was interviewed, and he said he does not complete the personal belongings lists.

The DoN and a Resident Care Manager (RCM) were interviewed and asked if the identified resident brought in outside medications. The RCM said she was not aware of any medications brought in by the identified resident. The DoN and RCM said when residents bring in medications, they are encouraged to have their family representative take the medications home for them, and if they can't, then any narcotic medications would be logged and locked up in the medication room. The RCM said no medications were ever logged and locked up in the medication room for the identified resident. The DoN also said she never offered to replace the identified resident's medication because she does not remember the resident or family member expressing concerns regarding missing medications.

Based on the records reviewed, the resident group interview and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident was not offered an evening snack and stated other residents were not offered evening snacks either.

FINDINGS #2:

The identified resident's October and November 2014 snack documentation was reviewed, and it documented the resident was offered snacks up to three times a day for a total of 44 offers, and the resident accepted the snacks 16 times and declined them 28 times.

Eleven residents in the group interview and four individual residents interviewed said they were offered evening snacks as well as at other times of the day. Three CNAs who worked the evening shift were interviewed and said they offered snacks each night.

Based on the records reviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident did not receive her scheduled pain narcotic medication because staff would not wake her up when it was time to be given.

FINDINGS #3:

The medication pass was observed by the survey team. Four different licensed nurses were observed to pass 26 medications, and they were all delivered on time and without any errors.

The identified resident's October and November 2014 Medication Administration Record (MAR) documented the scheduled narcotic was given as ordered. Ten other residents' MARs were reviewed and no missed medications were found. In addition, the identified resident's MAR documented the resident received a separate as needed pain medication on 56 other occasions that were given at different hours of the day and night.

Two licensed nurses were interviewed regarding scheduled pain medication and said they would give the medications as ordered, otherwise there may be adverse effects for the residents. They also said they would wake residents up to give the medication as ordered.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated bed sheets were not changed for three weeks for an identified resident.

FINDINGS #4:

Ten residents' bed sheets were observed for cleanliness, and no issues were observed.

Eleven residents in the group interview said bed sheets were changed at least twice a week, when they got their showers and/or baths, and had no concerns. During four individual residents' interviews and two residents' family member interviews, bed sheet cleanliness was not identified as an issue.

Two CNAs interviewed said bed sheets were changed at least twice a week, on bath days and on an as-needed basis.

Based on the records reviewed and staff interviews, it was determined the allegation could not be substantiated.

Bryan K. Lindsay, Administrator
January 9, 2015
Page 5 of 5

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated floors were not mopped, and there was dirt build-up on the floors.

FINDINGS #5:

Every resident's room in the facility was observed during the initial tour of the facility and other common area floors were observed throughout the survey; no dirt build-up was observed. During the survey, several housekeepers were observed mopping the floors in residents' rooms and other common area.

One housekeeper was interviewed and said residents' rooms are at least spot mopped daily.

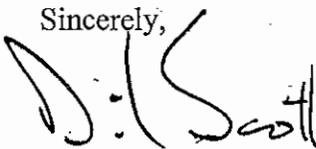
Based on the records reviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DJS/dmj